Health Promotion and Disease Prevention Strategies

MARILYN AGUIRRE-MOLINA, EdD
AMELIE RAMIREZ, DrPH
MARIO RAMIREZ, MD

Dr. Aguirre-Molina is an Assistant Professor, Department of Environmental and Community Medicine, Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey. Dr. Amelie Ramirez is Assistant Director of Administration and Community Health Promotion, South Texas Health Research Center, University of Texas Health Science Center, San Antonio. Dr. Mario Ramirez is with the Board of Regents, University of Texas Systems, Rio Grande City.

Tearsheet requests to Dr. Aguirre-Molina, 675 Hoes Lane, Piscataway, NJ 08854; tel. (908) 235-5041, 5042.

Synopsis

The rapid growth and relative youth of the Latino population of the United States, soon to become the largest ethnic-racial group in the country, presents numerous opportunities and a special challenge to those concerned with the health and well-being of this segment of people.

The challenge is to develop and implement efficacious strategies for improving Latino health at a time when the overall socioeconomic profile of this population is in striking contrast to that of the rest of the American people. Much can be done to improve Latino health by implementing health promotion and disease prevention interventions designed to achieve Latino parity in reaching year 2000 national health care objectives.

The problems encountered by Latinos in obtaining health promotion and disease prevention services, previous recommendations on how these problems could be addressed, and new strategies for implementing more effective services for Latinos are summarized.

THE TARGETS OF HEALTH promotion and disease prevention (HPDP) strategies are such health risk factors as individual behaviors, genetic predisposition, and exposures to environmental conditions that make populations vulnerable to one or more diseases. Reducing one or more risk factors adds years to people's lives and decreases medical costs (*1*).

HPDP interventions that reduce risk factors must include activities that foster empowerment. Sufficiently empowered, people are able to replace maladaptive behaviors with adaptive and productive ones; adopt health protection strategies that alter their social and physical environment to reduce exposure to harm or disease; and use such preventive health services as counseling, screening, and vaccination in clinical settings (*1*). Although HPDP interventions have brought about overall improvements in the health of the general U.S. population, Latinos have not been adequately represented among the groups who have benefited from these interventions (*2*).

In spite of limitations and gaps and inadequate collection methods, existing data provide a disturbing health profile of Latinos in the United States (*3*) (see table). A significant portion of deaths and diseases experienced by Latinos can be prevented or delayed by using known HPDP interventions, but numerous barriers keep Latinos from obtaining adequate and needed HPDP interventions.

HPDP Resources

Researchers at the Centers for Disease Control and Prevention (CDC) estimate that in 1988, a mere 0.7 percent ($32.8 billion) of the gross national product (GNP) was spent on health promotion and disease prevention in the United States (*4*), and the HPDP total represents only 3 percent of all health care expenditures allocated for prevention in the United States. In 1990, nearly 12 percent of the GNP went to treatment and medical services (*4*). The small HPDP allocation at the national level

'Compared with other groups in the United States, Latinos are least likely to have medical care benefits such as health insurance, Medicaid, and regular sources of care.'

illustrates the low priority given to interventions that are known to reduce morbidity and mortality, lost productivity, and early deaths (*2*).

The amount spent on specific population groups is not available, so it is not possible to assess the amount allocated for Latino HPDP interventions. Based on existing reports, however, it is safe to conclude that a minuscule amount of the 3 percent is devoted to HPDP among Latinos (*5–7*).

Access to Primary and Preventive Services

The degree to which Latinos are reached by HPDP interventions is determined to a great extent by their ability to access services where these interventions are available. The shortage of primary care facilities servicing Latinos creates serious barriers to HPDP services (*7*).

Compared with other groups in the United States, Latinos are least likely to have medical care benefits such as health insurance, Medicaid, and regular sources of care (*7–10*). Consequently, Latinos have less access to preventive and primary health care and lower rates of usage of needed health services (*5,6,10–14*). In particular, Latino youth and older adults make fewer health care visits per year than do non-Latino whites (*6*). Latino lack of access to sources of care produces a formidable barrier to HPDP programs.

Conversely, emergency room use is high among Latinos (*6*). This situation not only reflects the lack of a regular source of care, it also precludes access to HPDP interventions. Too often, problems treated in emergency room settings are beyond the scope of effective HPDP interventions. Even if intervention is timely, rarely are HPDP services available or offered in these settings.

Latino participation in the labor force does not ensure increased access to HPDP interventions. Latino overrepresentation in secondary labor markets (agriculture and manufacturing, for example) not only produces lower rates of employer-based insurance coverage but also increases Latino risks for occupational disease and injury (*1,9,14*). Additionally, employment in these sectors results in limited, if any, access to HPDP interventions, because these services are rarely provided (*1*).

Barriers to HPDP Interventions

Even when Latinos do have access to institutions where HPDP services are available, they encounter intrinsic, systemic barriers within the health care system. A description of this situation is offered in a recent report by the Department of Health and Human Services (*6*):

> The health care system in this country has been designed to serve the majority population and possesses limited flexibility to meet the needs of populations that are poor or may have different illnesses, cultural practices, diets, or languages ... Hispanics' obstacles to receiving [primary and preventive care] are magnified due to their special linguistic and cultural needs.

The following is a summary of these barriers:

Personnel. A significant barrier to HPDP services encountered by Latinos using dominant-culture institutions is the limited supply of bilingual and bicultural personnel (*5–7*). Often, Latinos are confronted by HPDP service providers who are either cross-culturally incompetent or not adequately trained to work with Latinos (*5*). This lack of competency manifests itself in exclusionary attitudes among health care providers; prejudice and discrimination in the delivery of services; misreading and misinterpretation of culturally determined behaviors, norms, and mores; and the design and delivery of culturally inappropriate and ineffectual HPDP interventions (*1,6*).

Institutions. Numerous other factors deter Latinos from accessing HPDP interventions in health care institutions. They include bureaucratic patient intake processes, many of which create the fear of deportation among the undocumented, long waiting times to make appointments or long waits at the time of the actual visit, and inflexible hours of service that are unresponsive to the local community's needs (*5,6,13*). Overall, existing practices do not produce health-promoting environments for those who approach them.

These negative experiences result in avoidance by Latinos of institutions that are not perceived to be user friendly or welcoming. The outcome is that

Rankings of 15 leading causes of death among ethnic groups, United States, 1987

Cause	Mexican	Puerto Rican	Cuban	White	African American
Heart disease	1	1	1	1	1
Malignant neoplasms	2	2	2	2	2
Cardiovascular disease	4	7	3	3	3
Accidents, adverse effects	3	4	5	5	4
Chronic obstructive pulmonary disease	11	10	9	4	[1]9
Pneumonia and influenza	8	8	7	6	6
Diabetes mellitus	6	9	8	7	7
Suicide	10	13	11	8	13
Chronic liver disease and cirrhosis	7	6	10	10	10
Atherosclerosis	15	15	14	9	14
Nephritis, nephrotic syndrome, and nephrosis	12	14	12	11	11
Homicide, legal intervention	5	5	6	15	5
Septicemia	13	12	13	12	12
Certain conditions in perinatal period	9	11	15	14	8
HIV infection	14	3	4	13	[1]9

[1] Tied. SOURCE: Tables 1–35, 1–6, Vital Statistics of the United States, 1987, vol. 2, pt. A, Mortality. National Center for Health Statistics, Hyattsville, MD, 1990.

they ignore early warning signs (when HPDP interventions would be more likely to be effective), and they do not use important screening services (*5,11*). The cumulative effect is that Latinos have lower rates of access to HPDP interventions because of institutional deterrents.

Program shortcomings. Regardless of Latinos' ability to pay for services, dominant-culture institutions have not provided linguistically appropriate, culturally sensitive, or culturally competent programs and services (*6*). This situation is manifested in programs that (*a*) fail to develop outreach methods that correctly target the population; (*b*) misunderstand the importance and role of family and social supports in promoting health and preventing disease within the Latino culture and fail to integrate these supports into HPDP interventions; (*c*) overlook intergenerational variations and acculturation among Latinos for the purpose of program planning; (*d*) discount intragroup diversity among Mexican Americans, Puerto Ricans, Cubans, and more recent arrivals from Central America and the Caribbean; and (*e*) fail to develop media strategies and materials that respond to the groups' needs and culture (*1,6,13, 15–18*).

Summary of Recommendations

Following is a summary of priority recommendations that national Latino organizations and leaders and other health officials recommend in response to the problems surrounding HPDP efforts for Latinos.

HPDP resources. U.S. health care expenditures allocated to HPDP (3 percent of the total) illustrate the low national priority placed on prevention. National priorities must shift so that proven prevention interventions and services are allocated the appropriate financial resources. Latino leaders agree that additional resources should be provided for health promotion and disease prevention activities targeted to Hispanics, and special focus must be placed on HPDP interventions that address the leading causes of morbidity and mortality among Latinos (*5*).

Data are needed to assess effectively the extent to which Latino HPDP needs are being met. Priority must be given to "develop[ing] and implement[ing] a national process to identify significant gaps in the nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs" (*2*).

Access to primary-preventive services. Numerous recommendations have been offered for removing the financial barriers that decrease the access of Latinos to health care settings where HPDP interventions may be obtained. Action is needed to implement these recommendations and thereby reduce or eliminate these barriers and improve access to primary and preventive care settings where HPDP services are available (*5,10*).

Removing barriers. To address the numerous institutional and systemic barriers encountered by La-

At its 1991 meeting, the National Hispanic Health Policy Summit organization called for immediate action to launch a national campaign that includes outreach and education and that focuses on critical Latino health needs such as HIV-AIDS, diabetes, and mental illness.

tinos seeking HPDP services, program support should be allocated to community-based organizations (CBOs) that have a history of providing effective services in Latino communities. The fact that these CBOs are already part of the community infrastructure makes them logical choices for increasing access (*5*). To achieve this end, there must be an increase in the number of culturally and linguistically appropriate community-based health promotion programs in counties throughout the United States that have high Latino population densities. The CBOs should not only house these programs, but they should also play an integral role in planning and implementing HPDP programs (*3*).

Personnel. The pool of bilingual and bicultural HPDP and other health personnel must be doubled by the year 2000 if the needs of Latinos are to be met (*3*). Existing service providers must be trained to deliver culturally relevant HPDP interventions to Latinos and to improve the quality of services provided (*6,12*). Latino leaders agree that Federal resources must be allocated for the education and training of these personnel. There is consensus that specific guidelines and protocols must be crafted to assist in the design and implementation of in-service training on multicultural awareness, sensitivity, and cultural competence (*5*).

Institutions. A great deal can be done to reduce institutional barriers to HPDP services through action on the preceding recommendations and work with the existing community-based primary care centers (*11*). Community-based services and centers are more likely to provide convenient service hours, decrease waiting time, provide more cross-culturally competent HPDP professionals, and offer culturally relevant outreach efforts that include education and transportation to reach those who may not be aware of existing HPDP services (*11,13*).

Programs. If health promotion and disease prevention efforts targeting Latino communities are to be effective, they must be culturally and linguistically relevant (*5,6*). To accomplish this objective, Latino leaders recommend that the Secretary of Health and Human Services "...mandate that all appropriate department services and financing programs address linguistic and cultural barriers to health care...." (*5*). Latino leaders agree also that those who have the primary responsibility for designing and implementing HPDP programs for Latinos should be affiliated with Latino CBOs currently servicing these communities (*5*).

Additional factors must be taken into consideration for HPDP program planning. They include intergroup variations, sex, and acculturation (*13, 15-18*). All of these variables affect the way in which program intervention strategies are developed.

National and Federal initiatives. At its 1991 meeting, the National Hispanic Health Policy Summit organization recognized the important role of coordinated, comprehensive national and Federal initiatives to address HPDP and related health needs of Latinos. To this end, the organization urged "a comprehensive plan with specific objectives and action for improving Hispanic health status and access to care... be developed and implemented by the Department of Health and Human Services and the Public Health Service in partnership with Hispanic health leaders" (*5*). The intent of such a plan is to produce a comprehensive and meaningful document, specific to Latino health, that goes beyond the health objectives for the year 2000.

The summit organization also called for immediate action to launch a national campaign that includes outreach and education and that focuses on critical Latino health needs such as HIV-AIDS, diabetes, and mental illness (*5*).

Considerations for Implementation

At the local, State, and Federal levels, efforts are currently under way to provide concrete implementation strategies for responding to the aforementioned recommendations. Many of these strategies warrant consideration for broader dissemination because of their apparent or potential effectiveness in addressing the HPDP needs of Latinos.

Following is a discussion of selected comprehensive interventions, as well as examples of what can be accomplished via existing publicly funded initiatives.

Community-based centers. In the absence of a well-integrated national effort to bridge the gap between the need of Latinos for preventive services and HPDP interventions, several local initiatives are responding to this need. For example, many Community and Migrant Health Centers and Community Mental Health Centers provide services tailored to Latinos (*6*).

These federally funded local HPDP initiatives represent concrete approaches that successfully respond to the problems and recommended solutions previously described. Their services are characterized by the availability of trained bilingual and bicultural personnel, cross-culturally competent staff members, culturally relevant programs that effectively use the media and successful outreach methods, and networks with other community providers that ensure proper linkages for referrals and service enhancements (*5*). Additionally, the organizational structure of these centers facilitates local community participation and input.

Closer review and assessment of these centers might reveal that broad expansion of the "center" model into additional Latino communities is a feasible strategy. These centers currently represent a health services model that delivers comprehensive, community-based, culturally relevant services that respond to the needs of Latinos.

Selected health promotion examples. New Jersey has launched an innovative HPDP campaign to improve maternal and child health in high-risk communities across the State (*10*). HealthStart, a Medicaid-funded program, attempts to improve accessibility and provide comprehensive HPDP services for all Medicaid recipients who are pregnant and to children younger than age 2.

HealthStart also includes aggressive outreach conducted by case managers, followup efforts launched at the State and community levels, training activities for service providers, program evaluation, and ongoing quality assurance activities.

The program is designed so that it takes cultural factors into consideration and includes innovative methods to serve the population best. The demographic profile (age, fertility patterns, and so on) of Latinos, and the problems they encounter in accessing primary-preventive and HPDP services, support the need for examining HealthStart's interventions further for broader program dissemination and adaptation.

A Su Salud is an innovative community-based public health intervention aimed at improving nutrition and cancer screening behaviors among Latinos in South Texas. Mass media messages support a community network of volunteers who promote positive role models while offering one-on-one encouragement to local citizens about improved health activity. Health promotion mass media campaign activities portray role models to promote positive health behavior. Featured individuals are members of the local community who have successfully integrated healthier behaviors into their lifestyles. The role model stories are presented in newsletter, newspaper, radio, and television formats. Currently, this program is being evaluated by the National Cancer Institute (*19,20*).

'Although HPDP interventions have brought about overall improvements in the health of the general U.S. population, Latinos have not been adequately represented among the groups who have benefited from these interventions.'

Culturally competent health personnel development. The Public Health Service operates a number of programs that recruit Latinos and train them to enter health and health-related careers. Through education and training programs for professionals assigned to underserved population sites, and through targeted recruitment and retention efforts, area health education centers attempt to enhance services to Latinos (*6*). Through grants to community providers and educational and other institutions, the Health Career Opportunity Program also attempts to provide continuity of support to minority students as they progress from high school through graduation from a health profession school.

These programs provide opportunities to expand the pool of cross-culturally competent Latinos in health careers, and they also represent vehicles that can be used to recruit and train individuals in primary-preventive care and HPDP services. The pool of Latinos who can effectively develop and implement HPDP interventions for Latinos is currently limited. Using these existing programs, an increased number of people must be trained to enter public health and health education if the need is to be met. Latino health professionals are needed for community settings, schools, and other institutions where Latinos can be reached for HPDP interventions.

References

1. Aguirre-Molina, M., and Molina, C. W.: Ethnic/racial populations and worksite health promotion. Occup Med 5: 789–806 (1990).
2. National Hispanic Healthy People 2000 Conference—summary document. National Coalition of Hispanic Health and Human Services Organizations, Washington, DC, 1991.
3. Healthy people 2000: National health promotion and disease prevention objectives. DHHS Publication No. (PHS) 91-50213, U.S. Government Printing Office, Washington, DC, 1991.
4. Estimated national spending on prevention—United States, 1988. MMWR Morb Mortal Wkly Rep 41: 529–531, July 24, 1992.
5. Hispanic Health Policy Summit Steering Committee: Summary of discussions and recommendations in assessing Hispanic health needs. (Draft) Washington, DC, Apr. 8, 1992.
6. Health care for Hispanic individuals. Report prepared for Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Department of Health and Human Services, Rockville, MD, 1991.
7. State of Hispanic America, 1991: an overview. National Council of La Raza, Washington, DC, 1992.
8. The state of Hispanic health. National Coalition of Hispanic Health and Human Services Organizations, Washington, DC, 1992.
9. Hispanics and health insurance. Vol.1, Status. Labor Council for Latin American Advancement and National Council of La Raza, Washington, DC, 1992.
10. . . . . and access for all: Medicaid and Hispanics. National Coalition of Hispanic Health and Human Services Organizations, Washington, DC, 1990.
11. Marks, G., Garcia, M., and Solis, J. M.: III. Health risk behaviors of Hispanics in the United States: findings from HHANES, 1982–84. Am J Public Health 80 (supp): 20–26, December 1990.
12. Solis, J. M., Marks, G., Garcia, M., and Shelton, D.: II. Acculturation, access to care, and use of preventive services by Hispanics: findings from HHANES, 1982–84. Am J Public Health 80 (supp): 11–19, December 1990.
13. Estrada, A. L., Treviño, F. M., and Ray, L. A.: IV. Health care utilization barriers among Mexican Americans: evidence from HHANES, 1982–84. Am J Public Health 80 (supp): 27–31, December 1990.
14. Hispanic access to health care—significant gaps exist. GAO 92-6. Government Accounting Office, Washington, DC, 1992.
15. Guendelman, S., Gould, J. B., Hudes, M., and Eskenazi, B.: X. Generational differences in perinatal health among the Mexican American population: findings from HHANES, 1982–84. Am J Public Health 80 (supp): 61–65, December 1990.
16. Haynes, S. G., et al.: VIII. Patterns of cigarette smoking among Hispanics in the United States: results from HHANES, 1982–84. Am J Public Health 80 (supp): 47–53, December 1990.
17. Amaro, H., Whitaker, R., Coffman, G., and Heeren, T.: IX. Acculturation and marijuana and cocaine use: findings from HHANES, 1982–84. Am J Public Health 80 (supp): 54–60, December 1990.
18. Markides, K. S., Ray, L. A., Stroup-Benham, C. A., and Treviño, F. M.: VII. Acculturation and alcohol consumption in the Mexican American population of the southwestern United States: findings from HHANES, 1982–84. Am J Public Health 80 (supp): 42–46, December 1990.
19. Ramirez, A. G., and McAlister, A. L.: Mass media campaign—A Su Salud. Prev Med 17: 608–621 (1988).
20. McAlister, A., et al.: Smoking cessation in Texas-Mexico border communities: a quasi-experimental panel study. Am J Health Promotion 6: 274–279 (1992).